RELEASE OF INFORMATION

Student_____ School_____

Date of Birth _____/_____/_____

Parent(s)/Guardian_____

Address_____ Phone _____

Your child has been referred for an evaluation for Special Education Services. Additional information is needed to assist in determining the need for special education. The information will be confidential and used only by persons directly involved with the student.

For this evaluation, we are requesting the information from the indicated contact person:

❑ Medical
❑ Social/Emotional
❑ Visual/Auditory
❑ Other: _____

Contact Name: _____
Address: _____
_____
Phone number: _____

In order to comply with federal law, your written permission is required so that the school system can receive information from the contact/doctor listed above. Please sign on the line below and return to _____ at his/her school. Thank you for your assistance in gathering this information needed for your child's assessment. If you have any questions regarding this request, please feel free to call (_____)_____/_____ for further clarification.

❑ I give permission to release information about my child to the _____ School System.

❑ I do not give permission to release information about my child to the _____ School System.

_____
Parent/Guardian Signature

Comments: _____
_____
_____
_____
_____

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Department of Education

MEDICAL INFORMATION

Student_____ School_____

Date of Birth _____/_____/_____

Parent(s)/Guardian_____

Address_____ Phone _____

Dear Physician:
This student has been referred for Special Education services. Medical information is needed to assist in determining the need for special education for this student. The information will be confidential and used only by persons directly involved with the student.

(Please respond to each item).

Diagnosis/Etiology: _____

Prognosis: _____

Is an evaluation available supporting the above diagnosis? ❑ Yes ... ❑ No

Please describe the impact of diagnosis on educational performance: _____
_____
_____

Treatment: _____
_____
Medication: (+Dosage): _____
_____
Type: _____

Major Learning Modality: (Check Applicable)
_____ Visual _____ Auditory _____ Tactile _____ Multisensory

Please make the most appropriate recommendation as to how this student can best function in an educational environment:

_____
_____
_____

Physician's Name (please print): _____
Authorized Signature: _____

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